International Centre for AIDS Care and Treatment Programmes

Increasing access to ART for clients who are diagnosed with Tuberculosis

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Introduction

- TB and HIV
- HIV and TB
- The Challenge
- Current guidelines
- Target groups
- Challenges and solutions for each group
- Summary
- Questions

TB and HIV

- TB is leading cause of mortality for HIV patients
- TB can infect at all stages of HIV
- TB diagnosis sometimes more difficult with HIV co-infection and often delayed
- TB therapy improves CD4 count
- TB therapy an adherence marker
- TB therapy reduces mortality for HIV patients

HIV and TB

- HIV increases incidence of TB
- Atypical presentations
- Diagnostic difficulties and delays
- Undiagnosed TB and IRIS
- Pill burden with ART and TB therapy
- Dosage alterations and increased monitoring
- ART reduces TB incidence (? Sustained)

The Challenge

- Not to produce a parallel “Fast tracking” but ensuring good implementation of current National ART guidelines.

- This can only be done with full participation of TB services, HIV directorate, Hospital and Primary Care

Opportunity Knocks!

- Ensure all TB clients are offered C&T. Those who test positive for HIV are staged, both clinically and with CD4 counts.
- Those who qualify for ART are referred to an ART provider in good time.
- Ensure all HIV+ clients who are being prepared for ART are screened for TB

Guidelines for ART with TB co-infection

- Category 1

  Stage I-III & CD4 >200 reassess on completion of TB therapy

- Category 2

  History stage IV &/or CD4<200 complete 2 months TB therapy before commencing ART

- Category 3

  CD4 <50 or other serious HIV illness commence ART once TB therapy tolerated (at least 2 weeks)

Clients from 3 target groups

- Acutely ill medical patients currently requiring district or referral hospital admission
- Patients in a TB hospital due to social/adherence reasons or medical convalescence
- Ambulant clients on DOTs at primary health care sites

District Hospital clients (1)

- Late disease spectrum with multiple pathologies
- Difficult, time consuming and expensive to manage
- High early mortality despite best efforts
- Poor management of TB

District Hospital (2)

- Clinical care (training / marketing of guidelines)
- Laboratory (who finances?)
- Access to ART in hospital wards
- Access to social & readiness programmes (cooperation from ART clinic, In-reach!)
- Down referral on discharge - continuity of care

TB hospital clients (1)

- ‘Specialist’ hospitals
- Unable to assess clients on-site
- Lack ability to give comprehensive treatment and care to all clients
- Clients from an extremely wide catchment area
- In-patient care only

TB Hospitals (2)

- Refer out clients, bring in an ART team or add service in-house?
- Funding issues (staff, drugs and labs)
- Improve Staffing and skill levels
- Is there an accredited site in reach of client once discharged?
- Have time, captive clientele and expertise in chronic adherence, registers, data capturing

Primary care clients (1)

- Few sites accredited for ART and those accredited are under pressure
- Currently referred to hospital ART sites, but long delays
- Old DOH clinics are cramped
- Some staff shortages
- Drug security

Primary Care (2)

- Earlier stage of illness
- Easier to manage with less complications
- Closer to clients home
- Less expense to all
- TB/VCT/PMTC/ARV/Family planning all in one place.
- Numerous municipality clinics under-utilised

Questions and Suggestions

Accredit an ART team who visit primary care sites on a weekly timetable to manage clients

Thank you